Approved POC Attached 4/15/19 SHN

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section Connecticut General Statutes 46a-150 and/or 19-13-D3 and/or (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).

1. *Based on clinical record reviews, facility policy reviews and staff interviews for five (5) of ten (10) sampled patients (Patients #2, # 7, # 8, #11 and #17) who were admitted to the Transitional Living Program (TLP), the hospital failed to ensure that bed checks and/or monitoring checks were completed in accordance with MD order, and/or that patients were reevaluated by the physician subsequent to identified concerns, and/or that suicide risk assessments were completed when the patient expressed suicidal thoughts, and/or patients were transferred to the acute unit as needed in accordance with facility policy. The findings include:
   a. Patient #2 was admitted to the facility on 1/22/18 with anxiety and depression and a recent suicide attempt. The patient had a history of pain and neurological autonomic dysfunction.
   Review of the Multidisciplinary Treatment Plan (MTP) dated 1/22/18 indicated that the patient's active problems included in part, Depression and Psychosis.
   A Residential Counselor (RC) note dated 2/15/18 at 2:22 PM indicated that Patient #2 had used the hospital's shared computer tablet and then returned to his/her room. After the computer tablet was returned there were concerning websites that were observed. RC #1's note indicated that this was shared with the treatment team members and that Patient #2 met with the treatment team to discuss the concerns.
   Interview with RC #1 on 2/13/19 at 1:30 PM indicated that she checked the unit computer tablet after Patient #2 had used it on 2/15/18 and was concerned about the websites the patient had visited. RC #1 reported this concern to the physician. Review of the physician's note dated 2/15/18 at 6:00 PM reflected that a review of the computer tablet history was completed by staff and identified searches related to suicide methods, autopsies, and an obituary in Patient #2's name. The note identified that Patient #2 repeatedly denied suicidal and homicidal ideation during the team interview and it was agreed that Patient #2 could stay in the transitional program safely and the patient would be reevaluated the next day (2/16/18).
   The record failed to reflect that a reevaluation of Patient #2 was completed on 2/16/18.
   Review of bed check documentation completed by RC #3 dated 2/17/18 indicated that bed checks were completed at 1:00 AM, 3:00 AM, 5:00 AM and 7:00 AM. The note indicated in part that the patient was observed sleeping through the night during periodic safety checks and no other issues at that time.
   A physician progress note dated 2/17/18 identified that the physician responded to a code on 2/17/18 at approximately 8:30 AM and upon arrival, Patient #2 was unresponsive, pulseless, cyanotic, and extremities were cold. Cardio Pulmonary Resuscitation (CPR) was in progress and continued with Emergency Medical Services (EMS), however, was unsuccessful.
   Interview with the Program Director on 1/14/19 at 11:20 AM indicated that at the time of

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the incident it was determined that the 7:00 AM bed check was not completed and RC #3's employment was terminated at that time. The Program Director indicated that the expectation is for staff to lay eyes on the patient and ensure that the patient's chest is moving.

Interview on 2/14/19 at 11:15 AM with the Director of the Transitional living program stated subsequent to this event, bed check policies were standardized throughout the transitional living programs, all staff were reeducated on the bed check policy, orientation was formalized, and physician reeducation was completed. The Director further stated that a committee was created and a cross section of staff meet monthly to address concerns and a "hotspot" reporting system was developed to allow staff to communicate any concerns on a daily basis which are reviewed by the Assistant Director of Transitional Living Program daily.

The Bed Check policy directed that the RC is responsible to check each bed making sure that the patient is breathing and the bed check form is to be completed only after having viewed the patient.

b. Patient #7 was admitted to the facility 1/23/19 with diagnoses that included anxious affect, emotional distress, flashbacks and intrusive thoughts. Review of the treatment plan dated 1/25/19 identified the patient with a mood disorder with interventions to identify triggers and coping skills.

Review of the clinical progress note dated 2/12/19 at 4:05 PM identified Patient #7 verbalized "I'm so depressed, I have constant thoughts about dying, like it would be good to just die, not that I'd stab myself in the heart or anything, it would just be a relief." "I've been pretending that everything's fine but I've been pulling out my hair at night, my thoughts are racing." The note identified that the MD joined the session and Patient #7 further identified that he/she had passive suicidal ideation but had also engaged in risky behavior. Patient #7 identified that on the way to the dining hall he/she crossed the street without looking either way, being hit by a car would be a relief, and stated that he/she had no plan or intent to kill self.

Review of the Transitional Living Program (TLP) MD progress note dated 2/12/19 at 3:15 PM identified that he met with the patient briefly with the Social Worker regarding reports that the patient is "freaking out", thoughts are racing, and the patient is finally feeling "how I usually am". The note identified that the patient feels that he/she was manipulating staff, that medications haven't been working, that he/she has been secretly pulling out hair at night, he/she has been secretly wishing not to wake up and was behaving in a risky way. The note further identified that Patient #7 did not have a specific plan to harm her/himself and reports that he/she will stay alive until the next day when he/she can meet with MD to discuss further options. Further review of the progress note identified that Patient #7 was to remain in the house on 30 minute checks until a meeting the following day and to withhold additional sharps.

The MD progress note failed to identify what withholding additional sharps meant.

A physician's order dated 2/12/19 at 3:06 PM directed to continue routine medications, Seroquel 50 mg every 2 hours as needed, not to exceed 100 mg and patient to remain in

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house with 30 minute checks until meeting tomorrow.
Review of the Residential Counselor Daily Shift Note dated 2/13/19 at 6:49 AM identified hed checks were completed to ensure patient safety every half hour from 11:00 PM to 6:30 AM. The note identified that the patient appeared to be asleep during checks.
Review of the daily report sheet on 2/13/19 at 10:30 AM identified under Patient #7's name, hoxes were drawn in and checked every half hour identifying that 30 minute checks were completed. Review of the report sheet noted that the time slots for 11:00 AM and 11:30 AM had already been checked even though it was only 10:30AM. Further review noted the documentation lacked the location of the patient, the behavior of the patient and who completed the checks.
Interview with Residential Counselor (RC) #2 on 2/13/19 at 10:30AM stated the patient reported during a session with Social Service of not wanting to wake up the next morning and subsequently 30 minute checks and house restriction were implemented until the physician could reevaluate the following day. RC #2 stated although the MD documented "withhold additional sharps", nothing was put in place to prevent the patient from obtaining sharps and she did not check the patient's room for sharps during the 30 minute checks. Tour of the TLP area and interview with RC #2 identified that the kitchen had knives and other utensils available/accessible to patients.
RC #2 further identified that she made check hoxes on the daily report sheet for the every half hour checks and was unsure if there was a policy in the transitional living units for every 30 minute checks.
Review of the clinical record with the Director of the TLP on 2/13/19 at 10:00 AM failed to identify that a suicidal risk assessment was completed when Patient #7 verbalized thoughts of wanting to die. Additionally, the treatment plan failed to identify suicidal ideation and/or interventions to monitor and/or assess the patient for safety. The TLP Director stated that recently, a new policy was implemented to complete a suicidal assessment on any patient who verhalizes suicidal ideation (SI) and/or has 3 or more increased risk factors on the daily diary sheets the patients complete.
Interview with the Director of the TLP on 2/13/19 at 11:00 AM stated that there is no policy for every 30 minute checks in the transitional living area. The Director stated that normally, patients check in every few hours as part of the program schedule. The Director further stated that there is no form to identify the location of the patient, the behaviors the patient may be exhibiting and who completed the checks.
Review of the TLP Physician Progress Note dated 2/13/19 at 11:02 AM identified that Patient #7 was still feeling dysphoric and anxious, has ongoing suicidal ruminations, no plans to harm self and does not feel he/she is a safety risk. Patient was agreeahle to taking the van to different places and having frequent checks, but doesn't feel/want that he/she needs to go inpatient. The note further identified the patient was agreeable to continued 30 minute checks and to increasing Seroquel.
Review of the Suicide Assessment policy for the Transitional Living Program identified an assessment will be completed if there is increased suicidal risk due to a patient's behavior and/or presentation, and if there is a 3 point increase in self-harm urges and/or suicidal

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ideation reflected on the patient's diary card. The policy further identified if the patient is scored as high risk the treatment team and/or nursing supervisor are notified and the patient will remain visible in the milieu until assessed by the on-duty doctor. Additionally, the policy directed that the doctor will order interventions indicated by conducting a mental status exam, clinical observation, a review of the Suicide Severity Rating Scale (C-SSRS) and collaboration with the treatment team, with possible interventions may include but not limited to transfer to a crisis bed or a higher level of care.

c. Patient #8 was admitted on 2/4/19 with diagnoses of depression, emotional distress and self-harm.

The Multidisciplinary treatment plan dated 2/5/19 identified personality disorder with interventions to educate the patient, medication management, and report the ability to manage self-harm impulses. Review of the Suicide Severity Rating Scale (C-SSRS) dated 2/12/19 at 5:27 PM identified the patient as high risk for SI.

Review of the TLP, Residential Counselor (RC) daily shift note dated 2/12/19 at 10:21 PM identified that Patient #8 requested skills coaching for increased sadness. The note identified the patient was tearful and crying while stating "I hurt so much and can't take it." The note identified Patient #8 was fearing a discharge living plan and being alone most of the time. The note further identified when the patient was asked questions regarding his/her safety the patient did not respond. When asked if the patient had a plan of self-harm Patient #8 responded "which place". The note identified the patient reported on planning to self-administer "all of his/her pills" when at home and has thoughts of eloping from the TLP program. Additionally, the note identified a suicidal risk assessment was completed and noted Patient #8 to be at high risk of self-harm. The Director was made aware, the physician assessed the patient and the patient was placed on a 1 to 1.

Review of the physician's progress noted dated 2/12/19 at 11:31 PM identified he/she was called to evaluate the patient after scoring high risk on the C-SSRS and thoughts of eloping. The note identified the patient was feeling frustrated because he/she was scared of having ECT therapy. The note identified that although the patient may commit suicide eventually at home or somewhere else, he/she does not have thoughts/plans of doing so at the facility. The note further directed staff to check the patient every 30 minutes.

Review of the daily report sheet on 2/13/19 at 10:45 AM identified under Patient #8's name, boxes were checked every half hour with a check mark. Additionally, upon review, the time slot for 11:00 AM had already been checked even though it was 10:45AM. Further review noted the documentation lacked the location of the patient, the behavior of the patient and who completed the checks. Interview with RC #2 at that time stated that she made those boxes for the every half hour checks.

Interview with the Director of the TLP Program on 2/13/19 at 11:00 AM stated that there is no policy for every 30 minute checks in the transitional living area, however, the RC's should not complete checks in advance.

The Director further stated that the policy identified if a patient scores high on the suicide assessment a possible intervention is to transfer the patient to a crisis bed or a higher level of care. The Director stated that Patient #8 should have been transferred to the acute side of

the hospital for an evaluation.

d. Patient # 17 was admitted 2/11/19 with diagnoses included anxious affect, emotional distress, and intrusive thoughts. Review of the TLP Residential Counselor daily shift note dated 2/12/19 at 7:07 PM identified a call was received from Person # 3 around 9:30 PM stating that Patient #17 was calling and didn't sound stable. The note further identified that MSW #1 checked on the patient who did not appear agitated or not stable but admitted to having an argument with Person #3. The note further identified that Person #3 called back to the facility and reported she was really worried because Patient #17 was saying scary things and demanding to be discharged. MSW #1 documented that he checked on the patient again who denied making any threats and showed no signs of distress. Additionally, the note identified the nursing supervisor was notified and bed checks would be increased to 30 minutes throughout the night. The note further identified the C-SSRS assessment (suicide assessment) was completed and the patient was a low risk for SI and the treatment team was notified.

Interview with MSW #1 on 2/15/19 at 4:40PM stated that Person #3 called to report that Patient #17 was saying scary things on the phone and felt the patient needed more observation. MSW #1 stated he went and spoke to the patient and felt there was no SI (Suicidal ideation) and was he/she stable. MSW #1 stated that Person #3 called again stating the patient was verbalizing suicidal ideation, not being rationale and needed to be in a crisis bed. MSW # 1 stated that he assured Person #3 that he had spoken to the patient and he/she denied making any suicidal ideations. MSW #1 identified he contacted the nursing supervisor, completed the suicidal assessment (low risk) and was directed to closely monitor the patient and place him/her on every 30 minute checks. MSW #1 stated that he reported to the 11-7 RC that the patient was to be monitored every 30 minutes per the nursing supervisor until seen by the MD.

Review of the TLP Residential Counselor daily shift note dated 2/13/19 at 7:04 AM identified bed checks were completed every two hours throughout the night and not every 30 minutes as directed from the nursing supervisor.

Interview with the Director of the TLP on 2/15/19 at 4:50PM stated that the night shift RC should have done the every 30 minute checks as the nursing supervisor ordered until the patient was seen by the doctor in the morning.

e. Patient # 11 was admitted on 1/28/19 with diagnoses of anorexia nervosa, borderline personality disorder, anxiety, depression and self-harm. The Multidisciplinary treatment plan dated 1/29/19 identified self-harm with interventions to educate patient on health consequences of high risk behaviors, feelings of self-harm and was on every 30 minute checks.

Review of the TLP daily shift note dated 2/6/19 indicated that Patient #11 had no self-harm behaviors. Review of the TLP Residential Counselor (RC) daily shift note dated 2/8/19 at 5:12 pm identified that Patient #11 had burned him/herself intentionally on his/her hand with a coffee maker a few days ago but never told anyone.

Review of the Suicide Severity Rating Scale (C-SSRS) dated 2/8/19 at 9:35 pm identified the patient as high risk for suicide ideation. Patient #11 was placed on every 15 minute

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checks.
Review of the TLP RC daily shift note dated 2/8/19 at 10:41pm (time that the note was written) identified that after the RC's hreak earlier in the evening, Patient #11 was found crying hysterically, rolling around and lightly humping her head against the ground. Patient #11 showed his/her hands to the RC that s/he had hurned him/herself earlier on the coffee machine when the RC was on hreak. Patient #11 sustained three medium size white spots on his/her left hand and knuckle. Patient #11 was assessed hy the nursing supervisor and the physician and was placed on every 15 minute checks for high risk for suicide. Patient #11 was not transferred out of the transitional living area to a higher level of care when identified as high risk for suicide ideation.
Subsequently on 2/11/19 (3 days later), Patient #11 was sent to the Emergency Department and treated for second degree burns to the left/right hands which included antibiotics and sulfadiazine topical ointment every day. Review of the clinician progress notes dated 2/8/19 on the 7-3pm/3-11pm shift failed to identify that every fifteen minute checks were documented in the daily shift notes.
Interview with the TLP Manager on 2/13/19 identified that after the patient had the second burn on 2/8/19, they removed the coffee pot, replaced it with a coffee pod machine and placed the patient on every 15 minute checks.
Interview with the Director of the TLP Program on 2/13/19 at 11:00 AM stated that there is no policy for every 30 minute checks in the transitional living area and the patients check in every few hours that is part of the program schedule. The Director further stated that the policy identified if a patient scores high on the suicide assessment a possihle intervention is to transfer the patient to a crisis hed or a higher level of care.
Review of hospital policy identified that patients who were assessed as a high risk for suicide would hy assessed hy the physician who would order interventions that may include a transfer to a crisis hed or a higher level of care.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2).

2. Based on review of the hospital's QAPl program, associated documentation, and staff interview, the hospital failed to develop and implement performance measures to include patient safety in the Transitional Living Programs (total of seven). The finding includes:
   a. Review of the hospital's QAPI program identified that the hospital's performance measures included patient falls, weight loss, and medication errors. The data collected through performance measures demonstrated that the data was heing analyzed, tracked, and included ongoing reviews of the performance measures.
   The hospital's QAPI program was reviewed with the Director, Performance Improvement and Risk Management on 2/27/19 at 9:20 AM. The QAPl program failed to include patient safety measures specific to the Transitional Living Program to include previously identified safety concerns with suicide risk assessments, safety monitoring and/or implementation of appropriate interventions to maintain patient safety. Although the hospital implemented

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suicide risk assessments in the TLP, the hospital failed to analyze the data gathered in the assessments or evaluate the effectiveness of patient safety interventions for patients identified as a moderate to high suicide risk.

The following is a violation of the Regulations of Connecticut State Agencies Section 227-14 (f) Medical Staff (A) and/or (B).

3. Based on clinical record review, interview and review of facility policy and procedure for one of three patients treated with Electroconvulsive Therapy (ECT) (Patient #3), the facility failed to ensure that post anesthesiology evaluations were completed thoroughly and timely. The finding included:
   a. Patient #3 was admitted on 1/17/19 with anxiety and depression, with the plan for (ECT). Review of the clinical record indicated that the patient had his/her first ECT treatment on 1/23/19.
   Review of continuing anesthesiology ECT record dated 1/25/19 identified that the patient's treatment started at 9:05 AM and finished at 9:30 AM. Review of the Post Anesthesia identified that the patient was evaluated at 9:30 AM. Indicating that the patient was evaluated in the procedure room immediately after the treatment rather than in the recovery room, after the patient's recovery period.
   Review of continuing anesthesiology ECT record dated 1/28/19 identified that the patient's treatment started at 8:06 AM and finished at 8:23 AM. Review of the Post Anesthesia identified that the patient was evaluated at 8:23 AM. Indicating that the patient was evaluated in the procedure room immediately after the treatment rather than in the recovery room, after the patient's recovery period.
   Review of continuing anesthesiology ECT record dated 2/11/19 identified that the patient's treatment started at 8:30 AM and finished at 8:55 AM. Review of the Post Anesthesia identified that the patient was evaluated at 8:55 AM. Indicating that the patient was evaluated in the procedure room immediately after the treatment rather than in the recovery room, after the patient's recovery period.
   Interview with RN # 6 on 2/14/19 at 2:05 PM identified that the time of the post ECT evaluation should not be the same as the finish time as the post evaluation should be conducted in the recovery room when the patient is alert.
   Review of the ECT policy identified that following every ECT treatment the attending anasethilogist will evaluate each patient and each post procedure evaluation shall occur in the recovery room.

The following are violations of the Regulations of Connecticut State Agencies Section 17-227-14 (h) Pharmacy (D) and/or (k) Support Services (3).

4. Based on observations, review of policies and procedures and interviews with facility personnel, the facility failed to ensure that medications were not expired before administration and/or that glucometer controls were labeled when opened. The findings include:

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a. During tour of the adolescent unit on 2/13/19 identified that seven vials of IV Haloperidol were expired as of 1/2019. Interview with the pharmacist on 2/13/19 indicated that medications are checked for expiration dates and they should have been removed and brought to the pharmacy. Review of hospital policy identified that monthly inspections of each nursing station for expired medications, cleanliness, and proper storage of medications will be conducted.
b. During tour of the main/adult unit on 2/13/19 identified that the glucometer quality controls were not labeled when opened. Interview with the nurse manager on 2/13/19 identified that the practice is to label the quality control bottles when they are opened and when they expire. Review of hospital policy indicated that the glucometer quality controls need to be in range before proceeding with patient testing, however, the hospital policy lacked the procedure for labeling the quality control vials with an open date and an expiration date.

The following are violations of the Regulations of Connecticut State Agencies Section 17-227-14 (f) Medical Staff (B) and /or (g) Nursing (C).

5. Based on a review of the clinical record, review of policies and procedures and interviews with facility personnel for two of three sampled patients (Patient #12, Patient #19), the facility failed to ensure that patients who required the Clinical Institute Withdrawal Assessment for Alcobol) CIWA were monitored in accordance of hospital policy. The findings include:
   a. Patient #12 was admitted to the hospital on 2/12/19 with substance abuse. Review of physician's orders dated 2/12/19 identified that the patient was to have a CIWA assessment completed every two hours while awake. Review of the CIWA assessment dated 2/12/19 from 12:00am-8:00am and 2/13/19 at 12:00am and 6:00am failed to indicate that a comprehensive CIWA assessment was conducted by the nurse. Interview with the Nurse Manger on 2/13/19 identified that the CIWA assessment was not documented on the night shift.
   b. Patient #19 was admitted to the hospital on 2/11/19 with substance abuse. Review of the physician orders dated 2/11/19 identified that the patient was to have a CIWA assessment completed every two hours while awake. Review of the CIWA assessment dated 2/11/19 from 12:00am-10:00am and 2:00pm, 2/12/19 from 12:00am-8:00am and 2/13/19 at 12:00am and at 6:00am failed to indicate that a comprehensive CIWA assessment was conducted by the nurse. Interview with the Nurse Manger on 2/13/19 identified that the CIWA assessment was not documented on the night shift.
   Review of hospital policy identified that documentation of the CIWA and/or COWS (Clinical Opiate Withdrawal Scale) assessment includes signs and symptoms of withdrawal, staff initials and RN signature and when the patient is sleeping at the time of a scheduled assessment, the CIWA/COWS may be documented as "sleeping" but all vital signs must still be measured as ordered.

DATES OF VISIT: February 13, 14, 15 and 27, 2019

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The following is a violation of the Regulations of Connecticut State Agencies Section 17-227-14 (f) Medical Staff A, B and/or 227-14(g) Nursing C, D and/or 17-227-14m Patient records B.

6. Based on clinical record review, interview and policy review the facility failed to ensure that the Master Treatment Plan was updated and/or individualized. The findings include the following:
   b. Patient #3 was admitted on 1/17/19 with anxiety and depression, with the plan for electroconvulsive therapy (ECT). Review of the clinical record indicated that the patient had his/her first ECT treatment on 1/23/19. Interview with Patient #3 on 2/13/19 at 10:20 AM indicated that the patient was frustrated with lack of activities and although there are some groups they are not appropriate for his/her treatment. The patient indicated that he/she is on the unit only to receive ECT, which is a four week program. Review of Social Work notes dated 1/24/19 indicated that the patient was having a hard time with increased down time, and the note dated 1/28/19 indicated that the patient had too much down time. Interview with the RN on 2/13/19 at 10:50 AM indicated that Patient #3 did not like group activities and preferred 1:1 interaction.
   Review of the Multidisciplinary Treatment Plan (MTP) dated 1/17/19 indicated that the patient's active problems were depression, fatigue, hopelessness/helplessness, poor appetite and self-deprecating ideation. The MTP comments dated 1/17/19 indicated that the patient continued to identify loneliness and being on a locked unit as triggers for mood disturbances, will continue to explore.
   Review of the MTP with the Director of Nursing on 2/15/19 at 1:15 PM indicated that the intervention for ECT was not incorporated into the treatment plan until 2/7/19. In addition, the MTP failed to be individualized to address the patient's concerns/needs related to too much down time and lack of activities. Interview with the DON on 2/15/19 at 1:10 PM indicated that patients are encouraged to attend all groups provided, however there is not a specific program related to patients receiving ECT.
   Review of the policy indicated that the coordination of the care is individualized and appropriate to support the patient's goals and needs.

DPH Corrective Action Plan
April 2019
Attachment 1

Finding #	Deficiency	Plan of Correction	Date of Completion	Monitor	Responsible Person
1.a	The record failed to reflect that a reevaluation of Patient #2 was completed on 2/16/18.	Physician who failed to reevaluate the patient was counselled in person by the Physician-in-Chief regarding the importance of reevaluating patients identified as increased acuity	2/19/18	100 % of all patients identified as at increased risk requiring milieu safety interventions will be monitored for compliance, to include required follow up evaluation. The monitor will be continued until 90+% compliance is sustained for a 4-month period.	Physician-in-Chief
	the 7:00 AM bed check was not completed	All staff members responsible for safety checks were reeducated on the correct procedure and documentation of same. Reeducation took place in person. No staff member was allowed to work a next shift without completing reeducation. -Reeducation was also completed in	3/27/18 2/26/18	30 charts/month will be audited for compliance with safety checks. The audit will be completed by the senior staff person in each transitional living house	Director of TLP

DPH Corrective Action Plan
April 2019
Attachment 1

		the RC staff meeting. -Policy revised to have standardized safety checks in all adult programs. -Staff educated on policy change via email	-4/6/18 -4/10/18		
1.b. 1.c 1.d 1.e	The MD progress note failed to identify what withholding additional sharps meant.	All Medical Staff have been educated that any safety related milieu interventions must be documented in a physician order and discussed with milieu for purposes of clarification and planning.	3/27/19 in Medical Staff Meeting	100 % of all patients identified as at increased risk requiring milieu safety interventions will be monitored for compliance. The monitor will be continued until 90+% compliance Is sustained for a 4-month period.	Physician-in-Chief
		All Residential Counselors have been educated to speak directly with MD regarding milieu safety intervention orders in the event the order is unclear or of concern	3/27/19	100 % of all patients identified as at increased risk requiring milieu safety interventions wll be monitored for compliance. The monitor will be continued until 90+% compliance is sustained for a 4-month period.	Dir. TLP/SW

DPH Corrective Action Plan
April 2019
Attachment 1

	Review of the report sheet noted that the time slots for 11:00 AM and 11:30 AM had already been checked even though it was only 10:30AM. Further review noted the documentation lacked the location of the patient, the behavior of the patient and who completed the checks.	TLP policy to be revised to address process for all observation levels, which will be consistent with our inpatient process	2/15/19	100 % of all patients identified as at increased risk requiring milieu safety interventions will be monitored for compliance. The monitor will be continued until 90+% compliance is sustained for a 4-month period.	Director of Transitional Living Program
		Tool will be created to document patients on increased observation at the time of the observation, to include where the patient was observed and how they are behaving, consistent with our inpatient process	2/15/19	100 % of all patients identified as at increased risk requiring milieu safety interventions will be monitored for compliance. The monitor will be continued until 90+% compliance is sustained for a 4-month period.	Director of Transitional Living Program
		Nursing Supervisors, Doctors and all residential counselors will be trained on the new	2/15/19- 2/22/19		Director of Transitional Living Program

		policy prior to starting next shift			
		TLP leadership will advise Nursing Supervisor daily of any patient on increased patient observation level. Nursing will monitor compliance with policy.	2/15/19	Nursing will monitor every patient on increased observation three times/week for the duration of the increased observation status.	Director of Nursing

DPH Corrective Action Plan
April 2019
Attachment 2

Finding #	Deficiency	Plan of Correction	Date of Completion	Monitor	Responsible Person
2.	Although the hospital implemented suicide risk assessments in the TLP, the hospital failed to analyze the data gathered in the assessments or evaluate the effectiveness of patient safety interventions for patients identified as a moderate to high suicide risk.	A monitor has been implemented to track every step of the process for identification, assessment, intervention, and documentation regarding TLP patients identified at increased acuity. The monitor data will be reviewed every morning in Leadership rounds, and aggregated data will be analyzed and reported to monthly Quality Council meeting	3/13/19	100 % of all patients identified as at increased risk requiring milieu safety interventions will be monitored for compliance. The monitor will be continued until 90+% compliance is sustained for a 4-month period.	Dir. TLP/SW

DPH Corrective Action Plan
April 2019
Attachment 3

Finding #	Deficiency	Plan of Correction	Date Completed	Monitor	Responsible Party
3.a. .	the facility failed to ensure that post anesthesiology evaluations were completed thoroughly and timely… the patient was evaluated in the procedure room immediately after the treatment rather than in the recovery room, after the patient's recovery period.	All anesthesiologists attending our ECT patients have been reeducated on our policy to evaluate the patient in the recovery room after the patient has recovered fully. Education carried out through email communication.	4/12/19	Documentation of 20 ECT treatments/month will be evaluated for correct post-anesthesia evaluation procedure. The monitor will be continued until 90+% compliance Is sustained for a 4-month period.	Physician-in-Chief

DPH Corrective Action Plan
April 2019
Attachment 4

Finding	Deficiency	Plan of Correction	Date Completed	Monitor	Responsible Party
4.a.	seven vials of IV Haloperidol were expired as of 1/2019	All stock medications and medications in Pyxis machines were audited to assure none were expired.	4/15/19	100% of medication stock items (including refrigerated items) will be checked by the night nurse once a month for expiration. Any medication expiring in the next month will be placed in the Pharmacy return bin. Pharmacy runs a weekly Pyxis report on expiring medications to alert tech to replace medications nearing the expiration date. Medications placed on the units will have a 90-day expiration date. Pharmacy will do a comprehensive quarterly review of all med rooms to assure no meds have expired.	Director of Pharmacy
4.b	Glucometer quality controls were not labeled when opened... the hospital policy lacked the	Via electronic communication, all nursing staff has been re-educated on the policy stipulating that QC vials must be labeled with the open date and	4/12/19	100% of all QC vials will be audited monthly by nursing to assure they are not expired and that they are labeled correctly	Director of Nursing

	procedure for labeling the quality control vials with an open date and an expiration date.	expiration date. All vials have been checked and labeled correctly.			

DPH Corrective Action Plan
April 2019
Attachment 5

Finding #	Deficiency	Plan of Correction	Date Completed	Monitor	Responsible Party
5.a and b	the facility failed to ensure that patients who required the Clinical Institute Withdrawal Assessment for Alcohol) CIWA were monitored in accordance of hospital policy... Hospital policy identified that..when the patient is sleeping at the time of a scheduled assessment, the CIWA/COWS may be documented as "sleeping" but all vital signs must still be measured as ordered	All Nursing staff has been reeducated on the requirement to document "sleeping" if the order for vitals or CIWA/COWS is written as "when awake". They are not to leave the field blank.	4/12/19	20 charts per month will be reviewed for correct CIWA/COWS documentation. The monitor will be continued until 90+% compliance is sustained for a 4 month period.	Director of Nursing

DPH Corrective Action Plan
April 2019
Attachment 6

Finding		Plan of Correction	Date Completed	Monitor	Responsible Party
6.b.	Patient 3 had his first ECT treatment on 1/23/19. The intervention for ECT was not incorporated into the treatment plan until 2/7/19.	All attending physicians have been reeducated on the requirement to add ECT as an intervention to the MDTP at the time the intervention is initiated. Education was through electronic communication and then in person at the Medical Staff meeting	4/12/19 4/17/19	100% of ECT records will be audited to assure the treatment plan includes the intervention of ECT at initiation. The monitor will be continued until 90+% compliance is sustained for a 4-month period	Physician-in-Chief
	In addition, the MDTP failed to be individualized to address the patient's concerns/needs related to too much down time and lack of activities.	All MDs and SWs have been reeducated on assessing the patients unique and changing needs overtime regarding programming and activities. Further they were educated to revise the treatment plans to meet these needs. As patients progress and are clinically appropriate to participate, these	Electronic communication on 4/12/19 MD staff meeting 4/17/19 SW staff meeting 4/16/19	30 charts per month will be audited to assure they include patient's need for increased or changed activities. The monitor will be continued until 90+% compliance is sustained for a 4-month period. Nursing will audit 100% of ECT patient records after 6 treatments	Dir. TLP/SW

		activities may include off unit gym use, walking groups, attendance at 12 step meetings, and participation in other programs		for patient progress allowing for expanded/changing activities/program.	